TEFRA/KATIE BECKETT CARE PLAN

Section A: To be Completed by Parent or Legal Representative

Personal History:

Applicant's Name: _____ DOB: _____ Applicant's Age_____

Applicant's Address: _____

Applicant's Telephone number_____

City: _____ State: _____ Zip Code: _____ County:_____

Social Security #: _____ Medicaid I.D. # _____

Family History:

Mother's name: _____ Father's name:_____

Mother's Educational level: _____ Father's Educational level: _____

Does Primary Caregiver work? ☐ Yes ☐ No Primary Caregiver's work schedule: Hours:_____

Does Secondary Caregiver work? ☐ Yes ☐ No Secondary Caregiver's work schedule: Hours: _____

Other Siblings: Name(s) _____ _____ _____

SCHOOL SERVICES/EDUCATION:

Is Child In School? ☐ Yes ☐ No ☐ # of hours per day in school: _____ # of days per week in school: _____

Does the child have a: ☐ IFSP or an ☐ IEP? ☐ Yes ☐ No

IFSP Current? ☐ Yes ☐ No

IEP Current? ☐ Yes ☐ No

If yes, (submit with application)

Level of Care In School:

☐ Skilled Nursing/Number of hours per day: _____

☐ Unskilled Nursing (Aide) Number of hours per day: _____

☐ Therapies: _____

Section B: To be Completed by Physician

Primary Care Physician(s) Name: _____

Primary Care Physician(s) Telephone Number: _____

Specialty Physicians: 1) _____ 2) _____ 3) _____

Diagnosis and/or Medical Problems:

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

MEDICATIONS: None_____ Medication: _____ Frequency: _____ Route: _____

Medication: _____ Frequency: _____ Route: _____

Medication: _____ Frequency: _____ Route: _____

Medication: _____ Frequency: _____ Route: _____

Medication: _____ Frequency: _____ Route: _____

MEDICAL INFORMATION:

Problem(s):	**Treatment Plan:**
_____	_____
_____	_____
_____	_____
_____	_____

HOSPITALIZATIONS: _____

_____

RESPIRATORY CARE: N/A:_____ Pulse Oximetry: _____CPT:_____

Trach Care: _____Suctioning/Frequency:_____

Is Recipient on O2? ☐ No ☐ Yes, if so: _____% Hours per Day _____

Ventilator ☐ During the Day # of Hours: _____ ☐ During the Night # of Hours _____

C-PAP or BI-PAP _____ Hours _____ ***(Please state)*** Day or Night _____

NUTRITIONAL THERAPY: Nutrition(s):_____ Oral/G-Tube/J-tube: _____

Frequency:_____ I.V. and/or TPN Information_____

Precautions: _____

EQUIPMENT: None_____Wheelchair_____Walking Devices_____Splints _____Other_____

CURRENT FUNCTIONAL STATUS: _____

THERAPIES (Physical, Speech, Occupational, other) ***include frequency per week and attach therapy notes*****:**

GOALS AND RECOMMENDATIONS: _____

LETTER OF MEDICAL NECESSITY (Must be Written by the Applicant's Physician)

Parent or Legal Representative Signature/Primary **Date**

Physician Signature/Primary **Date**

Parent or Legal Representative Signature (Secondary) **Date**

Social Worker or /DFCS Foster Care Worker **Date**

This document requires at least two signatures, the Primary Care Physician or Physician of record and Parent or Legal Representative (Caregiver's Signature). ** Foster care applicants must have the signature of the DFCS Representative.